

Northland Neurology & Myology, PA

David McKee, MD
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Neuromuscular and Electrodiagnostic Medicine Consultation

Name: Mancini, Mario
Date of Birth: 2/23/1972
DOS: 4/16/2019

Mancini, Mario
11007-041
FCU SST

Referring Physician: Jenefer Southwick, PA

PMH:

Medical History: .No Serious Illnesses Reported
Operative History: Cervical fusion of spine
Social History: .Social History Reviewed
Medications: Patient has no Current Medications.

ROS:

ALLERGIES:

General:	No data for Allergies
Head and Neck:	Noncontributory
Sleep:	Noncontributory
Heart Cardiovascular:	Narcolepsy
Pulmonary:	Noncontributory
Stomach Intestinal:	Noncontributory
Urinary:	Noncontributory
Muscular/Joint:	Noncontributory
Neuropsychological:	Arm pain;Hand/wrist pain;Neck pain Any numbness;Any tingling sensation

HISTORY: The patient was seen today on outreach in Moose Lake for assessment of right upper extremity complaints. He describes a history of neck pain which began in 2013. Eventually, he developed pain in the left arm and hand weakness for forearm extension. In November 2017 he underwent cervical fusion from C5-C7. He says that the neck pain resolved, but he has continued to have some paresthesia intermittently in the second digit of the right hand and he also perceives that there is weakness of the triceps, which has not improved. Symptoms have been relatively stable over the last year. He is asymptomatic for the left upper extremity and for both lower extremities.

PHYSICAL EXAMINATION: The patient is 68 inches tall and weighs 250 pounds. He is mesomorphic, but somewhat overweight. There is atrophy of the right triceps with fasciculations in that muscle. Muscle bulk is otherwise normal. Strength is 5/5 throughout for the upper extremities, including the interossei, finger extensors, forearm flexors and the shoulder girdle. On the right forearm extension is graded as just 4/5. Reflexes are absent at the right triceps, 2/4 at the left triceps and bilaterally for biceps and brachioradialis tendons. The gait is normal. Pinprick is intact in the C5-C8 dermatomes.

NERVE CONDUCTION STUDY: Motor nerve conduction velocity study testing was performed for the right median and ulnar nerves. Distal latencies were normal. Amplitudes of the wave forms were normal. Conduction velocities were normal, except for mild slowing of the ulnar nerve at the elbow.

H-reflexes were studied for the median and ulnar nerves with recording from the flexor carpi radialis and flexor carpi ulnaris respectively; latency was borderline prolonged for the ulnar nerve and no wave form could be obtained for the median nerve.

Antidromic sensory nerve conduction studies were performed for the second digital, radial and fifth digital nerves. Amplitudes, distal latencies and conduction velocities were normal.

J. SOUTHWICK, PA-C
HEALTH SERVICES
FCI SANDSTONE

JSPR 4.18.19

GOVERNMENT
EXHIBIT

16

20-CV-2532 (ECT/DTS)

USA_000783

Orthodromic mixed nerve conduction studies were performed for the median and ulnar nerves. Stimulation was at the palm; recording was proximal to the wrist. Latencies and conduction velocities were normal.

ELECTROMYOGRAPHY: Monopolar EMG needle examination was performed for the following muscles: right first dorsal interosseous, flexor carpi radialis, triceps, biceps, brachioradialis and deltoid. Fibrillations were prominent for the flexor carpi radialis and also seen for the triceps. These muscles showed moderate to severe denervation changes with enlarged wave forms.

IMPRESSION: The patient has fairly severe denervation in the right C7 myotome. Taken with the abnormal H-reflex for the median nerve, the findings are diagnostic of C7 nerve root injury or anterior horn cell loss at the C7 level, as might occur from cervical spinal cord compression at or above the C7. It is likely that the process is active, given the prominent fibrillations and the presence of some motor unit instability. The patient ought to undergo MRI to rule out ongoing compression.

There is slowing for the ulnar nerve at the elbow consistent with mild cubital tunnel syndrome. The importance of avoiding prolonged acute flexion of the elbow was discussed with the patient.



David McKee, MD
(Electronically Signed - 4/17/2019)

Diplomate, American Board of Neuromuscular and Electrodiagnostic Medicine
Diplomate, American Board of Psychiatry and Neurology

cc: